DEPARTMENT OF THE ARMY
UNITED STATES ARMY CRIMINAL INVESTIGATION COMMAND
11TH MILITARY POLICE BATTALION (CID)
48TH MILITARY POLICE DETACHMENT (CID)
APO AE 09342

CIMPL-FC 14 Nov 05

MEMORANDUM FOR SEE DISTRIBUTION

SUBJECT: CID REPORT OF INVESTIGATION – FINAL (C) – SSI – 0115-2005 –CID789-39270 – 5H6

DATES/TIMES/LOCATIONS OF OCCURRENCES:

1. 04 AUG 2005 1623; BAGHDAD CENTRAL CONFINEMENT FACILITY (BCCF); GRID: 38S MB130840; ABU GHRAIB, IRAQ (IZ)

DATE/TIME REPORTED: 04 AUG 2005, 1815

INVESTIGATED BY:
SA (b)(2), (b)(6), (b)(7)(C)

SUBJECT: 1. NONE; COMBAT DEATH

VICTIM: 1. UNKNOWN (DECEASED); INTERNMENT SERIAL NUMBER (ISN): US9IZ-176181-CI (BCCF 344TH FIELD HOSPITAL NUMBER 801-05-0726); MALE; WHITE; XZ; COMBAT DEATH (NFI)

THIS IS AN "OPERATION IRAQI FREEDOM" INVESTIGATION.

04 Aug 05, this investigation was initiated when MAJ (b)(6), (b)(7)(C) Surgeon, Task Force Medical, 344th Field Hospital, Abu Ghraib, IZ, notified this office of a Detainee who died in the hospital.

Investigation disclosed on 26 Jul 05, the Detainee was transferred to the Task Force Medical 344th Field Hospital, BCCF, Abu Ghraib, IZ. Despite life-saving measures, on 04 Aug 05, the Detainee experienced severe infection and multi-system organ failure; Therefore, attending doctors recommended no further escalation of care and the Detainee was pronounced dead at 1623, 04 Aug 05.

Further investigation revealed the Detainee received his injuries as a result of an altercation with U.S. Forces. The Final Autopsy Report listed the Cause of Death as Complications of Blast and Ballistic Injuries and the Manner of Death as Homicide. Therefore, his manner of death is listed as combat related.

STATUTES:

None

EXHIBITS/SUBSTANTIATION:

ATTACHED:

1. Agent's Investigation Report (AIR) of SA [(b)(6), (b)(7)(C)] 30 Oct 05, detailing the initial notification; exposing of photographs; receipt of medical file; receipt of Personal Data Report; medical coordination; AFIP coordination; and receipt of Final AFIP Report.

2. Photographic Packet containing Compact Disk of Detainee photographs

3. Medical file pertaining to Detainee 176181, 24 Jul – 4 Aug 05

4. Final Autopsy Report ME05-0821, 21 Oct 05

5. Detainee 176181 Personal Data Report (PDR)

6. AIR of SA [(b)(6), (b)(7)(C)] 18 Sep 05, detailing exposing of photographs, attending the autopsy, and coordination.

7. Photo CD ME05-0821, of autopsy, 30 Aug 05

NOT ATTACHED:

None

The originals of Exhibits 1, 2, and 6 are forwarded with the USACRC copy of this report. The original of Exhibit 3 is maintained in the files of Task Force -134 Detainee Operations, Camp Victory, IZ. The originals of Exhibits 4 and 7 are maintained in the files of the Office of the Armed Forces Medical Examiner (OAFME), Armed Forces Institute of Pathology (AFIP), 1413 Research Blvd, Bldg 102, Rockville, MD 20850. The original of Exhibit 5 is maintained in the files of the BCCF, Abu Ghraib, IZ.

STATUS: This is a Final (C) Report. This investigation is being terminated in accordance CIDR 195-1, Paragraph 4-17 (a)(6), in that the Special Agent in Charge has determined that furtherance of the investigation would be of little or no value or leads remaining to be developed are not significant. Commander's Report of Disciplinary Action taken is not required.

LEADS OUTSTANDING: Fully identify Detainee 176181.

Report Prepared By:

(b)(2), (b)(6), (b)(7)(C)

Special Agent, (b)(2), (b)(6), (b)(7)(C)

(b)(6), (b)(7)(C)

Special Agent in Charge

Distribution:

DIR, USACRC, 6010 6th Street, Fort Belvoir, VA 22060-5506
CDR, USACIDC, ATTN: CIOP-ZA, FORT BELVOIR, VA
(cid001crcsc@sbelvoirdms.army.smil.mil)
CDR, USACIDC, ATTN: CIOP-ZA, FORT BELVOIR, VA
(ciddcsops1sc@sbelvoirdms.army.smil.mil)
CHIEF, INVESTIGATIVE OPERATIONS DIVISION, USACIDC
((b)(6), (b)(7)(C)@sbelvoirdms.army.smil.mil)
(b)(6), (b)(7)(C)@sbelvoirdms.army.smil.mil)
DEPUTY CHIEF OF STAFF FOR OPERATIONS, USACIDC
(b)(6), (b)(7)(C)@us.army.smil.mil)
CID CURRENT OPERATIONS, USACIDC
(ciddcsops1sc@sbelvoirdms.army.smil.mil)
CDR, 3RD MILITARY POLICE GROUP (CID)
((b)(6), (b)(7)(C)@force1.army.smil.mil)
CDR, 11TH MILITARY POLICE BN (CID) (FWD)
(b)(6), (b)(7)(C)@iraq.centcom.smil.mil) (b)(6)(b)(7)(C)@iraq.centcom.smil.mil)
CDR, 48TH MILITARY POLICE DET (CID) (FWD)
((b)(6), (b)(7)(C)@iraq.centcom.smil.mil)
1- SJA, 43RD MP BDE, MNC-I, CAMP VICTORY, BAGHDAD, IZ
((b)(6), (b)(7)(C)@iraq.centcom.mil)
1- SJA, 452ND MP DET, 43RD MP BDE, MNC-I, BCCF, ABU GHRAIB, IZ
((b)(6), (b)(7)(C)@iraq.centcom.smil.mil)
1- DET SGT, 48TH MILITARY POLICE DET (CID) (FWD)
(b)(6), (b)(7)(C)@iraq.centcom.smil.mil)
CDR, DETAINEE OPERATIONS, MNF-I, DETAINEE OPS
(b)(6), (b)(7)(C)@iraq.centcom.smil.mil)
1- SA, Armed Forces Institute of Pathology (AFIP), Rockville, MD
((b)(6), (b)(7)(C)@us.army.smil.mil)
1 - File

AGENT'S INVESTIGATIVE REPORT

CID Regulation 195-1

ROI NUMBER 0115-2005-CID789-39270

DETAILS: BASIS FOR INVESTIGATION:

About 1815, 04 Aug 05, this office was notified by MAJ (Doctor) (b)(6), (b)(7)(C) Task Force 344th Med Field Hospital, Baghdad Central Confinement Facility (BCCF), Abu Ghraib, Iraq (AGI), that a detainee had died at the hospital.

Deceased: UNKNOWN DETAINEE, No Internment Serial number (ISN) at this time, Hospital Number 801-05-0726.

About 1830, 04 Aug 05, the undersigned received a copy of the Detainee medical file from SSG (b)(6), (b)(7)(C) NCOIC PAD, 344th Field Hospital, BCCF, AGI.

About 1200, 05 Aug 05 the undersigned interviewed DR (b)(6), (b)(7)(C) and obtained a copy of the death certificate. DR (b)(6), (b)(7)(C) related the Detainee had been transferred from the 86th Combat Support Hospital (CSH), International Zone, Baghdad, IZ. The Detainee arrived at the 344th on 27 July 05, suffering from close range blast injuries. DR (b)(6), (b)(7)(C) stated the Detainee has been in ICU since his arrival and he never regained consciousness or showed any signs of recovery. DR (b)(6), (b)(7)(C) related all life saving measures were unsuccessful and the cause of death is multi-system organ failure due to necrotizing fascitis (severe infection) resulting from burn and blast injuries to the upper torso, abdomen and upper extremities. DR (b)(6), (b)(7)(C) explained nothing unusual was found and the time and date of death was 1623, 04 Aug 05.

Agent's Comment: A review of the documentation included in the medical file from the 86th CSH revealed the UNKNOWN DETAINEE was admitted there on 24 July 05, after being injured in an altercation with U.S. Forces wherein the UNKNOWN DETAINEE was injured by a grenade as he was behind a door that Coalition Forces were attempting to breach. (See 86th CSH Discharge Summary and Sworn Statements by SPC (b)(6), (b)(7)(C) and (b)(6), (b)(7)(C) (b)(6), (b)(7)(C)

About 1600, 29 Oct 05, the undersigned received the AFIP Final Autopsy Report from the 48th MP Det (CID), Camp Slayer, Iraq. The Cause of death is listed as Complications of Blast and Ballistic Injuries; Manner of Death is Homicide. (Combat Death).

TYPED NAME, SEQUENCE NUMBER	ORGANIZATION
SA (b)(2), (b)(6), (b)(7)(C)	48th MP Det (CID)(FWD)(-), BCCF, AGI, APO AE 09342
SIGNATU (b)(6), (b)(7)(C)	DATE 30 Oct 05 / EXHIBIT 1

AGENT'S INVESTIGATIVE REPORT

CID Regulation 195-1

ROI NUMBER 0115-2005-CID789-39270

DETAILS: BASIS FOR INVESTIGATION:

About 1600, 30 Oct 05, the undersigned received the Personal Data Report (PDR) pertaining to the Detainee from SSG Cindy BARROIS, 105-68-8039, In-Processing Non Commissioned Officer In Charge (NCOIC), Internment Holding Area (IHA), BCCF, AGI.///LAST ENTRY///

TYPED NAME, SEQUENCE NUMBER
SA (b)(2), (b)(6), (b)(7)(C)
(b)(6), (b)(7)(C)

ORGANIZATION
48th MP Det (CID)(FWD)(-), BCCF, AGI, APO AE 09342

DATE 30 Oct 05

EXHIBIT 1

0115-05-CID789-39270

Photo Packet

EXHIBIT 2

Exhibit 3

Pages 9 thru 32 referred to:

CDR USAMEDCOM
ATTN: FOIA Office, STOP 76
1216 Stanley RD 2D FL
FT. Sam Houston, TX 78234-5049

CERTIFICATE OF DEATH *(OVERSEAS)*
Acte de décès *(D'Outre-Mer)*

NAME OF DECEASED *(Last, First, Middle)* Nom du décédé (Nom et prénoms)	GRADE Grade	BRANCH OF SERVICE Arme	SOCIAL SECURITY NUMBER Numéro de l'Assurance Sociale
Unknown, Unknown 801 05 0726 Reg# 82			(b)(6)
ORGANIZATION Organisation	NATION *(e.g., United States)* Pays	DATE OF BIRTH Date de naissance	SEX Sexe ☒ MALE Masculin ☐ FEMALE Féminin

RACE Race	MARITAL STATUS État Civil	RELIGION Culte
☐ CAUCASOID Caucasique	☐ SINGLE Célibataire	☐ DIVORCED Divorcé
☐ NEGROID Négroïde	☐ MARRIED Marié	☐ SEPARATED Séparé
☐ OTHER (Specify) Autre (Spécifier)	☐ WIDOWED Veuf	☐ PROTESTANT Protestant
		☐ CATHOLIC Catholique
		☐ JEWISH Juif
		☐ OTHER (Specify) Autre (Spécifier)

NAME OF NEXT OF KIN Nom du plus proche parent	RELATIONSHIP TO DECEASED Parenté du décédé avec le susdit
STREET ADDRESS Domicilé à (Rue)	CITY OF TOWN AND STATE *(Include ZIP Code)* Ville (Code postal compris)

MEDICAL STATEMENT Déclaration médicale

	CAUSE OF DEATH *(Enter only one cause per line)* Cause du décès (N'indiquer qu'une cause par ligne)	INTERVAL BETWEEN ONSET AND DEATH Intervalle entre l'attaque et le décès
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH [1] Maladie ou condition directement responsable de la mort. [1]	MULTISYTEM ORGAN FAILURE	3 days
ANTECEDENT CAUSES — MORBID CONDITION, IF ANY, LEADING TO PRIMARY CAUSE Condition morbide, s'il y a lieu, menant à la cause primaire	NECROTIZING FASCITIS	6 days
Symptômes précurseurs de la mort — UNDERLYING CAUSE, IF ANY, GIVING RISE TO PRIMARY CAUSE Raison fondamentale, s'il y a lieu, ayant suscité la cause primaire	BLAST/BURN INJURY (R) CHEST ABD + UPPER EXTREMITY	8 days
OTHER SIGNIFICANT CONDITIONS [2] Autres conditions significatives [2]		

MODE OF DEATH Condition de décès	AUTOPSY PERFORMED Autopsie effectuée ☐ YES Oui ☒ NO Non	CIRCUMSTANCES SURROUNDING DEATH DUE TO EXTERNAL CAUSES Circonstances de la mort suscitées par des causes extérieures
☐ NATURAL Mort naturelle	MAJOR FINDINGS OF AUTOPSY Conclusions principales de l'autopsie	
☐ ACCIDENT Mort accidentelle		
☐ SUICIDE Suicide	NAME OF PATHOLOGIST Nom du pathologiste	
☐ HOMICIDE Homicide	SIGNATURE (b)(6) (b)(6) 05	AVIATION ACCIDENT Accident d'Avion ☐ YES Oui ☐ NO Non

DATE OF DEATH *(Hour, day, month, year)* (b)(6) 05 — PLACE OF DEATH Lieu de décès

I EXAMINED THE REMAINS OF THE DECEASED AND DEATH OCCURRED AT THE TIME INDICATED AND FROM THE CAUSES AS STATED ABOVE.
J'ai examiné les restes mortels du défunt et je conclus que le décès est survenu à l'heure indiquée et à la suite des causes énumérées ci dessus

NAME OF MEDICAL OFFICER Nom du médecin militaire ou du médecin sanitaire	TITLE OR DEGREE Titre ou diplôme
GRADE Grade	INSTALLATION OR ADDRESS Installation ou adresse
DATE Date	SIGNATURE Signature

[1] *State disease, injury or complication which caused death, but not mode of dying such as heart failure, etc.*
[2] *State conditions contributing to the death, but not related to the disease or condition causing death.*
[1] *Préciser la nature de la maladie, de la blessure ou de la complication qui a contribué à la mort, mais non la manière de mourir, telle qu'un arrêt du cœur, etc.*
[2] *Préciser la condition qui a contribué à la mort, mais n'ayant aucun rapport avec la maladie ou à la condition qui a provoqué la mort.*

EXHIBIT 93

HOSPITAL REPORT OF DEATH

FOR USE OF THIS FORM, SEE AR 40-400; THE PROPONENT AGENCY IS OFFICE OF THE SURGEON GENERAL

NAME AND LOCATION OF HOSPITAL

Prepare, in one copy only, Items 1 through 10 and sign Item 11. Print or type entries.

Instructions - Medical Officer in attendance will: Send form, without delay to the Registrar or Administrative Officer of the Day, for necessary action and for preparation of required number of copies.

SECTION A - ATTENDING MEDICAL OFFICER'S REPORT

PERSONAL DATA

1. PATIENT DATA *(Patient's ward plate will be used to imprint identifying data if available)*

UNKNOWN, UNKNOWN

PSN#801 05 0726

Reg#C000082 / ICU / Bed #3

Patient's name (Last, first, middle initial) Grade, Social Security Account No., Register Number and Ward Number

2. TIME OF DEATH *(Hour day month year)*: 16:23

3. MEDICAL EXAMINER/ CORONER'S CASE: ☒ YES ☐ NO

4. RELIGION

5. CHAPLAIN NOTIFIED: ☐ YES ☒ NO

6. NAME, ADDRESS AND RELATIONSHIP OF RELATIVE OR FRIEND PRESENT AT DEATH

CAUSE OF DEATH

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7a. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury, or complication which caused death)*	DUE TO *(or as a consequence of)* MULTISYSTEM ORGAN FAILURE	3 DAYS
7b. ANTECEDENT CAUSES *(Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last)*	DUE TO *(or as a consequence of)* (1) NECROTIZING FASCIITIS	6 DAYS
	(2) BLAST / BURN INJURY Ⓡ CHEST, ABD & UPPER EXTREMITY	8 DAYS
8. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	a.	
	b.	

9. DATE	10. TYPED OR PRINTED NAME AND GRADE OF MEDICAL OFFICER IN ATTENDANCE	11. SIGNATURE OF MEDICAL OFFICER IN ATTENDANCE
(b)(6) 05	(b)(6)	(b)(6)

SECTION B - ADMINISTRATIVE ACTION

TYPE OF ACTION	HOUR	DAY	MONTH	YEAR	INITIALS OF RESPONSIBLE OFFICER
12. TELEGRAM TO NEXT OF KIN OR OTHER AUTHORIZED PERSON					
13. POST ADJUTANT GENERAL NOTIFIED					
14. IMMEDIATE CO OF DECEASED NOTIFIED					
15. INFORMATION OFFICE NOTIFIED					
16. POST MORTUARY OFFICER NOTIFIED					
17. RED CROSS NOTIFIED					
18. OTHER *(Specify)*					
19.					

SECTION C - RECORD OF AUTOPSY

20. AUTOPSY PERFORMED *(If yes, give date and place)*: ☐ YES ☒ NO

21. AUTOPSY ORDERED BY *(Signature)*

22. PROVISIONAL PATHOLOGICAL FINDINGS

23. DATE	24. TYPED NAME AND GRADE OF PHYSICIAN PERFORMING AUTOPSY	25. SIGNATURE OF PHYSICIAN PERFORMING AUTOPSY
26. DATE	27. TYPED NAME AND GRADE OF REGISTRAR	28. SIGNATURE OF REGISTRAR

DA FORM 3894, OCT 72 REPLACES DA FORM 8-257, 1 JAN 61, WHICH WILL BE USED. USAPA V2.01

EXHIBIT 10

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
4 Aug 05	Medicine
9 AM →	Patient seen and examined
	Discussed on multidisciplinary Rounds
	overall condition continues to deteriorate
	O_2 Requirements continue to Rise FiO_2 90%
	Urine output decreasing & Rising BUN, Creatinine,
	Acidosis, Hyperkalemia
	outlook is grim. There are No dialysis facilities
	we Have Hoxed out on our options
	He is DNR
	The unanimous decision of ICU Team ((b)(6)
	is to withdraw Support and Continuing Current efforts
	will be futile
	(b)(6)
4 Aug 05 1623	Medicine
	Pt expired (b)(6)
	Monitor aspirated
4 Aug 1625	Pt was in asystole } Respiratory arrest & decreasing SATS and BP (2 systolic)
	the 40's. Dr declared pt dead. Pt had Renal failure and pulmonary
	failure. Was on Diprivan @ 49 ml/°, Fentanyl @ 35 ml/°, Insulin @ 3 l/°,
	TPN @ 60 l/°, Lipids @ 40 l/°, 0.45% NS @ 99/°. Was on ventilator

STANDARD FORM 509 (REV. 5/1959) BACK
EHSPA V1.00

EXHIBIT 7

11

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
3 Aug 2005 2300 hrs	Pt vomited dark, bilious fluid from mouth & nose. (b)(6) notified. Moderate amt noted. Reglan 10mg IVP x1 given. This occurred ≈ 2100 hrs. 1 episode, ↑ HR & ↑ BP noted. Fentanyl drip ↑ 0.2mcg/kg/min. Propofol gtt ↑ 100mcg/kg/min. MSO_4 4mg IVP given @ 2230 hrs in prep for wound care. Pt tolerated wound care fairly well. (b)(6) arrived & assessed pt. Dobhoff tube D/C'd. Salem Sump inserted (b) mares & placed to LIS. Dark, bilious drainage noted. Ø distress noted. Will continue to monitor pt closely. (b)(6)
4 Aug 2005 0130 hrs	VSS x SpO_2. SpO_2 ↓ 92%. Pt suctioned orally, nasally & through trach for minimal secretions. RT notified (b)(6) FiO_2 ↑ 70%. Ø distress noted. (b)(6)
0650 hrs	Pt ↓ continuously ↓ SpO_2 noted. FiO_2 ↑ 80%. (b)(6) notified & assessed pt. Mucomyst & Albuterol nebs given x1 as ordered @ 0600 hrs. MSO_4 4mg given @ 0600 hrs in prep for wound/NM care. SpO_2 ↑ 95%. Pt tolerated wound care, NM care & trach care fairly well. Ø further episodes of N/V noted. Pt afebrile @ this time. All (b)(6) further redrain/dressings remain intact. Safety precautions maintained. Ø distress noted. (b)(6)

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*		REGISTER NO.		WARD NO.

(b)(6)

UNKNOWN, UNK
NO DETAINEE
IHA

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1969)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.4(b)(10)
USAMA V1.00

EXHIBIT 123

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
3 Aug 05	Medical Nutrition Therapy - Re-Assessment
	Pt in renal failure labs: 130 | 104 | (63) / 112 ; 4.5 | 14 | (4.2)
	EEN: ~~35~~ Kcal/Kg = 2600Kcal (b)(6)
	EPN: 0.6 - 0.8g/Kg = 44 - ~~60~~ 59g error
	~~Rec ↓TPN to 40cc/hr which provides 919Kcal, 41g pro~~
	~~ΔTF to Osmolite @ 20cc/hr which provides 480Kcal,~~
	~~21g pro and 404cc free H2O. Total intake 1400Kcal,~~
	~~62g pro and 404cc free H2O. If able to D/C TPN~~
	P/R (1) D/C TF
	(2) ↓TPN to 60cc/hr, lipids daily =
	61g pro, 1734Kcal (67% Kcal needs)
	(3) Monitor BUN, Cr, Phos
	(4) Will follow (b)(6)
3 Aug 1845	Pt stable and sedated all day. TF was D/C'd in A.M.
	and Lipid were started Q D. Pat. pat minimal suction and ? secretion
	often bubble from nose. Spiked a temp @ 1630, tylenol was given.
	(b)(6)
3 Aug 2005 2000 hrs	Pt received @ 1900hrs sedated on Propofol & fentanyl gtts. @ facial grimacing [illegible] opening of eyes noted to suctioning & noxious stimuli. Febrile @ this time. Tylenol given as ordered. Frequent suctioning required (R) nares c̄ frothy secretions noted. Safety precautions maintained. Rewards & procedures explained to pt. Ø distress noted. See ICU flowsheet for completion of assessment. (b)(6)

STANDARD FORM 509 (REV. 5/1999) BACK

EXHIBIT

13

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	Medicine
3 Aug 05	Patient seen and examined on Rounds
	overall seems to be Holding
	Hemodynamically stable
	B.P 128/67 P 107 Temp 100
	Intubated and sedated
	SIMV Rate 16 FiO2 60 PSV 20 Peep 10
	Intake 6162
	output 2085
	Labs 
	PO4 9.4 Mg
	Mg 2.7 "
	Creat 4.2 Mg
	Blood cultures .. + staphylococcus aureus.
	Imp: 1) Hemodynamically stable
	2) Non oliguric ATN
	3) Sepsis (staphylococcus aureus)
	Plan - will adjust Meds for the degree of Renal failure
	on Imipenem
	will add gatifloxin 400 Mg loading Dose 200 Mg Q8

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST Coni FIRST DNR MI | SPON ISSN (b)(6) (b)(6)

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No. or SSN; Sex; Date of Birth; Rank/Grade)

(b)(6)

UNKNOWN, UNK
NO DETAINEE

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1980)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1)
USAPA V1.00

EXHIBIT 14

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
08/02/05	pt has 100.4 fever Tylenol suppos. (R) given @ 0600 pt fluid now -45% Saline @ 60cc/hr. pt FS 172 (b)(6)
8/2/05	Medicine Patient seen and examined Discussed at length on Rounds Condition overall deteriorating Has Acute Renal failure in addition to other System failure By Mutual agreement (M.D's + Nurses) He has been Made DNR Prognosis Sean grim (b)(6)
8/2/05	MNT- F/U. Conts to receive TF@ 20cc/hr, TPN @ 80cc/hr Diprovan- 33cc/hr. Labs: 133 | 108 | (48) | 1561 (alb 1.0) 3.9 | 15 | (3.1) Nutrition provided meets est needs, however pt not responding well DNR- as of today. Will cont to follow prn (b)(6)

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME: LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
PATIENT (b)(6)		REGISTER NO.	WARD NO.	

INKNOWN, UNK
N O DETAINEE
IH.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1988)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(3)

EXHIBIT

15

DATE	NOTES
8-1-05	Trauma — Op Note
16:20	Pre-op Dx 1. H/o necrotizing fasciitis (R) arm.
	2. Superficial necrosis abd wall fascia
	3. Superficial necrosis (R) pectoral muscle & RUE
	Guillotine amp.
	Post Dx Same
	Proc 1. Debridement abd wall, pectoral & RUE and [illegible]
	(b)(6)
	EBL 200.
	Findings Necrotic skin & sub Q (R) abd, necrotic
	fascia abd wall. Superficial necrosis (R)
	pect m. & RUE m.
	Path sent on fascia
	Cx's sent (R) pectoral region (b)(6)
	Will add imipenem to abx until
1 AUG 2005	Pt received @1900hrs sedated on Propofol & fentanyl gtts. Propofol gtt titrated to maintain
2100hrs	optimal sedation. Ø distress noted. All meds & procedures explained to pt. Dsg Δs
	performed as ordered. See ICU flowsheet for completion of assessment. Pt febrile.
	Tylenol given @2000hrs. Will continue to monitor closely. (b)(6)
2400hrs	Pt remained febrile. Tylenol given as ordered. Ø Δs noted to previous assessment.
	Ø distress noted. (b)(6)
2 Aug 2005	Pt febrile despite Tylenol. HR, BP & Resp ↑. Facial grimacing noted. Propofol gtt ↑ [illegible]
0230hrs	@0200hrs. Insulin gtt cont. titrated according to hourly FS. Physical assessment unchanged
	Ø distress noted. (b)(6)
0600hrs	Pt tolerated AM care fairly well. Dsg Δs done as ordered. Sites appear to be healing
	c granulating tissue noted. Safety precautions maintained. Ø distress noted.
	(b)(6)
	Addendum (b)(6) notified of AM lab results. Ø orders given @ this time. (b)(6)

STANDARD FORM 509

DATE	NOTES
8-1-05	Trauma – DD Note
16:20	PRE-OP DX 1. H/T NECROTIZING FASCIITIS (R) ARM.
	2. SUPERFICIAL NECROSIS AND WOUND FASCIA
	3. SUPERFICIAL NECROSIS (R) PECTORAL MUSCLE & RUQ
	CHEST WALL
	POST OP DX: SAME
	PROC 1. DEBRIDEMENT ARM WOUND, PECTORAL & RUQ CHEST WALL
	(b)(6)
	ESL: 206.
	FACES NECROTIC SKIN & SUB Q (R) ARM, NECROTIC
	FASCIA ARM WOUND. SUPERFICIAL NECROSIS (R)
	PECT M. & RUQ M..
	PATH GIVEN TO [illegible]
	CX'S SENT (R) PECTORAL REGION. (b)(6)
	WOUND AND INSTRUCTION TO NSX UNTIL ST
1 AUG 2005	Pt received @ 1900hrs sedated on Propofol & fentanyl gtts. Propofol gtt titrated to maintain
2100hrs	optimal sedation. Ø distress noted. All risks & procedure explained to pt. Dsg Cs performed as ordered. See ICU flowsheet for completion of assessment. (b)(6)
	Tylenol given @ 2000 hrs. Will continue to monitor closely.
2400 hrs	Pt remained febrile. Tylenol given as ordered. Ø Cs noted to previous assessment. (b)(6)
	Ø distress noted.
2 Aug 2005	Pt febrile despite Tylenol. HR, RR & Resp ↑. Facial grimacing noted. Propofol gtt ↑ for sedation
0230hrs	@ 0200 hrs. Insulin gtt cont. titrated according to hourly FS. Physical assessment unchanged
	Ø distress noted.. (b)(6)
0600 hrs	Pt sedated & RN care given well. Dsg Cs done as ordered. Sites appear to be healing
	& granulating tissue noted. Safety precautions maintained. Ø distress noted.
	(b)(6)
	Addendum – (b)(6) notified of AM lab results. Ø orders given @ this time. (b)(6)

(b)(6)

DATE	NOTES
07/31/05 2100	Pt was given 2nd unit of B neg Blood 250cc as ordered. no adverse reaction noted. MD notified. Pt continues on Propofol 33cc/hr Fentanyl 20cc/hr TPN 90cc/hr & Insulin drip as per sliding scale for FS. (b)(6)
0700	Pt due for OR this AM. TF of Levity @ 20cc/hr via DOBNOFF tube on hold @ midnight as ordered. All dsg clean & Dakin W-D. (b)(6)
	Medicine
1 Aug 05	Patient seen and examined
	Discussed at length & Round
	Intubated and sedated
	Temp 100.5 B.P 124/58 SIMV 12 FIO_2 40% Sats 100%
	Intake 55-90
	output 2180
	Labs 10.5 / 7.3 / 22.3 / 35 — 139 / 113 / 30 — 3.9 / 18 / 2.4
	Transfused 2 units of Packed ABG - 7.4 PCO_2 26.7 HCO_3 18.5
	Red cells yesterday
	Femoral cather. Typ + A-line Typ - Resp asp growing
	gram Negative Rods
	on Cef tazamic + clindamycin
	(b)(6)

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
Jul 31-05	Medicine
	Chart reviewed POD - 2
	Shrapnel Burn w/ Chest + Abd Areas
	Monitoring facility (b)(6)
	104 101/57 15 99
	12 650 10 25
	I/O 5590/2180 3412
	CVRRR
	Resp + BS (L)
	Abd Surg Burns Abd
	Labs pending ABG 7.45/26/6 / 18.9/94
	Imp 1) S/P Shrapnel / Burns wounds Dry Slowly
	2) R Arm Amputation 2° to Arm Fxs RUE + Chest
	3) Vent - Dependant
	4) Nutrition/GI Starting TF
	5) Metabolic labs pending (b)(6)

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME: LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

DATE	NOTES
7-30-05	Team - OP Note
	Pre-op Dx 1. Shrapnel Burn wound RUE chest & Abd
	2. Necrotizing Fasciitis
	Post Dx Same
	Proc 1. Irrigation wounds 6
	2. Debridement wounds
	3. Suction Pressure
	4. (L) Femoral triple lumen placement
	5. Dobhoff tube placement
	Surg (b)(6) (b)(6)
	Asst. Ø
	EBL minimal
	Compl Ø
	Findings Superficial debris pictures & abd wound
	viable muscle & fascia
1800 30 Jul 05	Pt is s/p wound debridement & dressing
	A's. (L) Fem TLC placed, (R) Fem TLC & (R)
	Subclavian TLC D/C. PICC Placed Approx
	1745. waiting for placement confirmation.
	Pt v/s within Norms — (b)(6)
30 Jul 05 2105	Pt remains sedated. s/p wound
	debridement. PICC was D/C'd by (b)(6)
	v/s remain WNL — (b)(6)
31 Jul 05 0710	MD gave order to start TF @ 20cc/hr via
	Dobhoff tube in (L) nare; Diprivan ↑ to 80 mcg/kg/min &
	TPN ↑ to 90cc/hr. no abnormal changes in v/s. (b)(6)

STANDARD

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
30 Jul 05 0700	Pt c ↑temp @ 2400 @ 102.2 ^ Tylenol sup given. Temp ↓ 100.4 by 0500. MgSO4 & KPhos given via IV. MD order labs CBC BMP & ABG 1° after KPhos finished. Abdominal, (R) Stump (R) rectoral dsg done - w-D Dakins; skin around wounds c application of silvadene oint. Pt remains sedated. (b)(6)
0750	K Phos finished at 0730. LABS to be drawn @ 0800. As per report, Pt had temp overnight treated by tylenol sup. Temp ↓. (b)(6)
(b)(6)	
31 Jul 05	Patient seen and examined - Intubated and sedated
	B.P 109/57 P 110
1109	Blood culture sent due to spike in temp to 100.5 (b)(6)
	Discussed at length on Rounds (b)(6)
	Necrotizing Fasciitis Left arm - underwent amputation
	antibiotics changed to Cefotaxime and Clindamycin
	@ anterior chest wound does not look good
	For OR later today (b)(6)
	Flow 40% Peep 10 Sats 100

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME (LAST, FIRST, MI) | SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No. or SSN; Sex; Date of Birth; Nationality) | REGISTER NO. | WARD NO.

(b)(6)

UNKNOWN, UNK
NO DETAINEE
IKF

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

EXHIBIT 3

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
29 Dec 03	Ortho paedic Consult Intra operative findings included complete loss of Skin from 80% of volar surface of arm & multiple intra muscular abcesses of the fore arm and elbow region, In light of extensive purulence & ischemic appearance of the muscle the long-term viability of the arm is extremely doubtful. Given that the exposed muscle tissue also imposes fluid management and potential septic complications, the decision was made between surgeons to amputate the arm. Decision was cleared C DCCS, (b)(6) (b)(6)

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MIDDLE

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAIN

PATIENT'S IDENTIFICATION: (b)(6) | REGISTER NO.

UNKNOWN, UNK
H O DETAINEE
IHA

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
7-29-05	Trauma POD #1
	AVS. BP = 134/60 RR 12/12 SIMV 650 FiO_2 60%
	~~SB~~ Sat 100%
	WO 550-200/0
	PE: LCS. COARSE BS
	CORD, RHL.
	ABD: BS HYPERACTIVE
	EXT - SUPERFICIAL PURPURIC RUE varicosities
	(R) LOWER 2° BURN CLOSED
	IMP: (b)(6) S/P (R) CLOSED, ABD, RUE
	PLAN: REMOVE OR TODAY
	WILL LIKELY CONVERT TO NS VOT TO DAY OR MONDAY IF SUCCESSFUL FOR TOTAL ABD. CONTINUE VAC.
	MAY NEED FURTHER DEBRIDEMENT RUE & CHEST
	(b)(6)

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME (LAST, FIRST, MI) | SPONSOR'S ID NUMBER (SSN or Other)

DEPARTMENT/SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade) | REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
7-27-05	Trauma OP NOTE PRE-OP DX BLAST INJURY FACE (R) ARM ANT CHEST & ABD POST OP DX SAME PROC: 1. DEBRIDEMENT ABRASIONS 1ST 2-D + 3-D DEGREE BURNS ≈ 20% TOTAL 2. DEBRIDEMENT 3-D DEGREE BURNS 3. DEBRIDEMENT DEVITALIZED PERITONEUM MUSCLE & PLACE BULK DRESSINGS SURG (b)(6) EBL = 300 COMP FINDINGS: AS ABOVE
7/28/05 10:30	Procedure Note: Right femoral vein triple lumen Cath inserted, pt tolerated procedure well all lines patent & flushed. (b)(6)

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SPONSOR'S ID NUMBER (SSN or Other)

DEPARTMENT/SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)
(b)(6)

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

DATE	NOTES
7-28-05	TRAUMA - OP NOTE
16:30	PRE-OP Dx: (R) CHEST, ABD, & RUE SUBAPEX.
	& BURN WOUNDS
	POST Dx I SAME
	2 FULL THICKNESS BURN c MILD SWELLING
	(R) ANT LOT ABD WALL
	PROC: I, DEBRIDEMENT ABOVE.
	2. REMOVAL FULL THICKNESS BURN ABD WALL
	3. VAC x 3.
	4. CLOSE BURN EXCB → BACKBACK ONLY
	(b)(6)
	DISSID
	EBL 200
	FLUIDS:
	COMPLS
	(b)(6)
7-29-05	OT
0111:30	TEMP. SAM splint in forearm position to prevent contracture provided. Leave as needed for PROM Ex.
	(b)(6)

STANDARD FORM 509 (REV. 5-99) BACK

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
7-27-05	Trauma
	45 y/o [illegible] SUSTAINED CLOSE RANGE BLAST INJURY
	W/ LARGE SOFT TISSUE DEFECT (R) CHEST WALL PECTORALIS &
	(R) DIAPH. PENETRATING (R) ABD INJURY. PT TRANSFERRED
	TO OR FOR EXP LAP (R) COLECTOMY W
	ILEOSTOMY ANASTOMOSIS ADMITTED AS TRANSFER FOR 8th
	CASE.
	PMH PSH MEDS ALL: UNK
	PE: HEENT CONJ PINK
	NECK NON-TENDER
	BACK NON-TENDER W/ INJURY
	CHEST CLEAR BS
	ABD BS HYPERACTIVE MIDLINE INCISION
	EXT SOFT TISSUE DEFECT PECTORALIS, (R) SUBMAMMARY TO WOUND.
	LABS 132 / 3.7 / 103 / 25 / 11 / 0.7 / 189 ; 10.5 / 32. / 70 / 180
	7.42 | 36.5 | 60 | 91. | 24 → 70% INTUBATED 7.PEEP

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)		REGISTER NO.	WARD NO.	

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

DATE	NOTES
1-8	1. (R) COLONIC INJURY — BARIUM ENEMA x 3-5 d.
	2. VENT DERANGEMENT — ? ARDS — FLU AVAR TODAY.
	3. EXTENSIVE BURNS (R) ALL CLOTHES & ABD WOUND → DEBRIDEMENT IN OR TODAY
	4. NUT — STAT TP — DIETICIAN REFER. — DAT. — ELECTRICAL TRICKLE FEEDS
	5. HYPOKALEMIA — REPLACE
	6. ↓ Ca, Mg, PHOS.

(b)(6)

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
0760 2005/07/27	Pt awaiting debridement and cleaning out of wounds Pt awake, RR, Pt on vent SIMV pulse ox 98% Bloods drawn, labs sent. Pt vital signs assessed, Pt to go to OR for trache placement and clean out of his wounds
0900	requested 2 units of Blood for [redacted] OR (b)(6)
0900	Pt in OR (b)(6)
1235	Pt returned RR from OR Pt while assess Pt on vent, via trach post op Bloods drawn, post op xray required (b)(6) (b)(6)
1700	Pt BP ↓ propofol from 100mg/kg/min → 85mg/min LN
27 July 05 1900	Received pt in supine position, sedated, trach → vent in SIMV mode. Breath sounds clear, equal bilaterally & equal chest expansion. Dsg to wound on (R) arm, upper (R) chest wall, Abdomen and (R) leg noted & serosanguinous drainage. Burn dsg on trunk covering all wounds. All lines are patent and infusing well.
2000	Finger stick 254/251 (b)(6) informed of the same insulin drip rate increased to 5 u/hr for titration as ordered by (b)(6). Will continue to monitor.
2100	Finger stick 273 (b)(6) informed of the same. (b)(6)
2140	(b)(6) made clarification to insulin gtt order and rate increased to
2200	14 u/hr as ordered. Medications given as ordered no adverse reactions noted. (b)(6)
2200	Finger stick 273 refill. (b)(6) informed of the same rate remains @ 14 u/ (b)(6)

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST, FIRST, MI | SPONSOR'S ID NO. (SSN or Other)

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade) | REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.206(b)(1u)

DATE	NOTES
27 July 05	Continue to monitor FS and titrate as ordered (b)(6)
2300	FS 251 insulin gtt decreased to 13U/hr as ordered. (b)(6)
	Pt had an elevated temperature tylenol given as ordered, no adverse reactions
0330	noted. Dsg to wound sites changed, minimal bleeding noted to (R) arm and
	wound on upper (R) pectoris, abdominal wound site is reddish in color. Wound to (R)
	leg pinkish in color no odor noted at wounds sites. Burn dsg applied to
28 July	sites as ordered. NG→ LIC suction no drainage noted in collection container scanty green along tubing
0610	All therapies maintained as ordered. Pt is in no apparent distress (b)(6)
28 July	Received pt in bed pt remains sedated. All lines are patent and
1900	infusing well no signs of infiltration noted at sites. Pt remains on
	q1° accucheck for FS, maintained on insulin gtts. Post site c wound vac
	X3 functioning well. Site to wound on chest wall and (R) leg no sign
	of drainage noted dsg clean c dry. NGT→LIS small amt of greenish secretions noted in canister.
2200	Medication given as ordered no adverse reaction noted. (b)(6)
29 July 05	Insulin gtt titrated as per MD's order. (b)(6)
0400	Pt temp. elevated at this time tylenol given and cooling measures
	applied. Dsg changes to wound done as ordered sites are reddish [illegible]
0600	Temp 99.5 at this time. All therapies maintained as ordered.
	All lines are patent c intact c infusing well (b)(6)
29 July 05	Patient given IV red blood cells starting to 12:50.
	BP = 145/61; P = 106; T = 93.5
	15min BP = 146/64; P = 107; T = 93.5 without reaction.
	Second bag in OR
	last sugar blood = 259 given increased insulin to 20
	taken blood for ABG, CBC, BMP, Mg, P, Ca.
	Patient c Diprivan 70 mcg/kg/min; Fentanyl c 0.1 mcg/kg (b)(6)

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
26 July 05	Received pt in bed in supine position, pt is orally intubated c ETT taped securely. Pt is sedated therefore he is unresponsive. Breath sounds clear, equal bilaterally. Generalized peppering noted on pt's trunk face, upper, lower extremities. Q arm is elevated c dsg, minimal amt of serosanguinous fluid. Abdominal dsg clean, intact, also dsg to upper Q chest wall clean, intact.
27 July 05 0020	(b)(6) [redacted]
0320	(b)(6) [redacted] exposed of elevated temp Tylenol given temperature remains persistently elevated x1 dose of Tylenol given @ 0320 es per MD's order. Cooling measures applied to arm pits, head.
0345	Dsg changes done, no odor noted, sites are reddish in color wet to dry dsg applied. Medications given as ordered no adverse reactions
0530	noted. All therapies maintained as ordered pt is in no
0600	acute distress. (b)(6) [redacted]

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME (LAST, FIRST, MI) | SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*

(b)(6) [redacted]

UNKNOWN, UNK
N O DETAINEE
IHA

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

(b)(6)

86th Combat Support Hospital
Ibn Sina Hospital
Baghdad, Iraq

(b)(6)

DATE OF DICTATION: July 24, 2005

Discharge Summary/Aeromedical Evacuation Summary

Patient: (b)(6)
SSN: (b)(6)

Date of Admission: July 24, 2005
Date of Discharge/Transfer:

NARRATIVE SUMMARY OF HISTORY OF PRESENT ILLNESS & HOSPITAL COURSE:

Host nation ~~civilian~~ male, sustained multiple penetrating shrapnel wounds in a close-proximity blast injury with large soft tissue defects of the right chest wall / pectoralis and right arm, as well as penetrating injury of the right abdomen. He was taken emergently to the operating room, where exploratory laparotomy revealed a traumatic colostomy at the hepatic flexure with no visible contamination of the peritoneal cavity; right hemicolectomy with primary ileocolic stapled anastamosis was performed. The mesenteric window was closed. The abdomen was irrigated and closed at the fascia primarily; the skin wound was left open. The right chest wall and arm wounds were debrided of nonviable tissue, involving the pectoralis muscles, as well as the biceps, triceps, brachioradialis, and extensor and radial flexor compartments. Postoperatively he remained intubated over the following 24hrs; he remained hemodynamically stable without further blood product requirements. He was extubated and transferred to the ward. He is transferred out of the 86th CSH in satisfactory, stable medical condition.

DISCHARGE DIAGNOSES:

1) Multiple penetrating shrapnel wounds with:
   a. Penetrating colon injury (hepatic flexure)
   b. Massive soft tissue loss of right pectoralis, right arm
   c. Scattered lacerations: right abdomen, chest, neck, face
   d. Diffuse superficial peppering/burn wounds of the face, neck, torso, and extremities

PROCEDURES DURING ADMISSION:

1) Exploratory laparotomy, right hemicolectomy with primary ileocolic stapled anastamosis
2) Irrigation/debridement of right chest wall and right arm wounds
3) Primary repair, right ear wound

MEDICATIONS ON TRANSFER/DISCHARGE:

1) Unasyn 3gm IV q8hr (72hrs total)
2) Morphine 2-10mg IV q2hr PRN
3) Zantac 50mg IV q8hr
4) Heparin 5000u SQ BID

CONDITION: Stable for Transfer

Patient: (b)(6)
SSN:

PLAN/RECOMMENDATIONS:

1) Advance diet as tolerated once bowel function resumes
2) Attentive wound care, with twice daily dressing changes of right arm, midline abdominal wound, and multiple open shrapnel wounds. Would recommend return to the operating room in next 24-48hrs for repeat debridement of soft tissue wounds of the right chest wall and arm.
3) Bacitracin or similar topical ointment to superficial burn/char injuries of skin: right torso, neck, face appear most significant
4) Please contact me here at the 86th CSH if you have questions regarding his care

(b)(6)

SWORN STATEMENT

PRIVACY ACT STATEMENT

AUTHORITY: Title 10 USC Section 301; Title 5 USC Section 2951; E.O. 9397 dated November 22, 1943 (SSN). # 3586

PRINCIPAL PURPOSE: To provide commanders and law enforcement officials with means by which information may be accurately identified.

ROUTINE USES: Your social security number is used as an additional/alternate means of identification to facilitate filing and retrieval.

DISCLOSURE: Disclosure of your social security number is voluntary.

1. LOCATION	2. DATE (YYYYMMDD)	3. TIME	4. FILE NUMBER
86th CSH, BAGHDAD	20050724	1338	

5. LA(b)(6), (b)(7)(C)	6. SSN (b)(6), (b)(7)(C)	7. GRADE/STATUS
		CIV

8. ORGANIZATION OR ADDRESS
C 3/7 CAV

9. I, (b)(6), (b)(7)(C), WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:

At approx 0600 24 July our security patrol came under SAF in Baghdad. The two individuals ran up to the house while ~~the~~ individuals were attempted to breech the door with a grenade. The two guys were on the other side and suffered injuries. We then transported them to CSH.

NOTHING FOLLOWS

10. EXHIBIT	11. INITIALS OF PERSON MAKING STATEMENT	PAGE 1 OF ___ PAGES

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT OF _____, TAKEN AT _____, DATED _____"

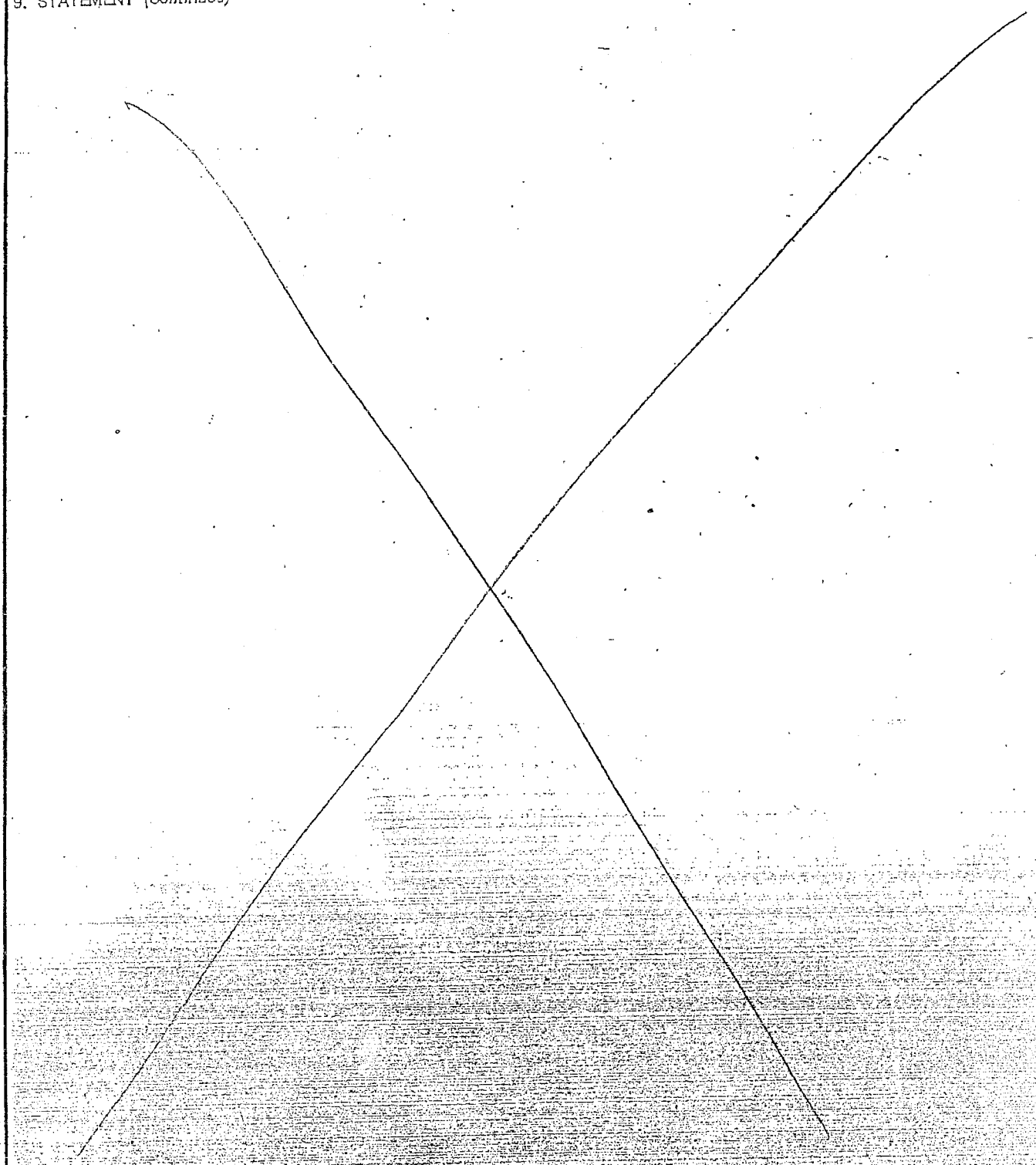
THE BOTTOM OF EACH ADDITIONAL PAGE MUST BEAR THE INITIALS OF THE PERSON MAKING THE STATEMENT, AND PAGE NUMBERS MUST BE BE INDICATED.

DA FORM 2823, DEC 1998 — DA FORM 2823, JUL 72, IS OBSOLETE — USAPA V1.00

EXHIBIT 333

STATEMENT OF _____ TAKEN AT _____ DATED _____

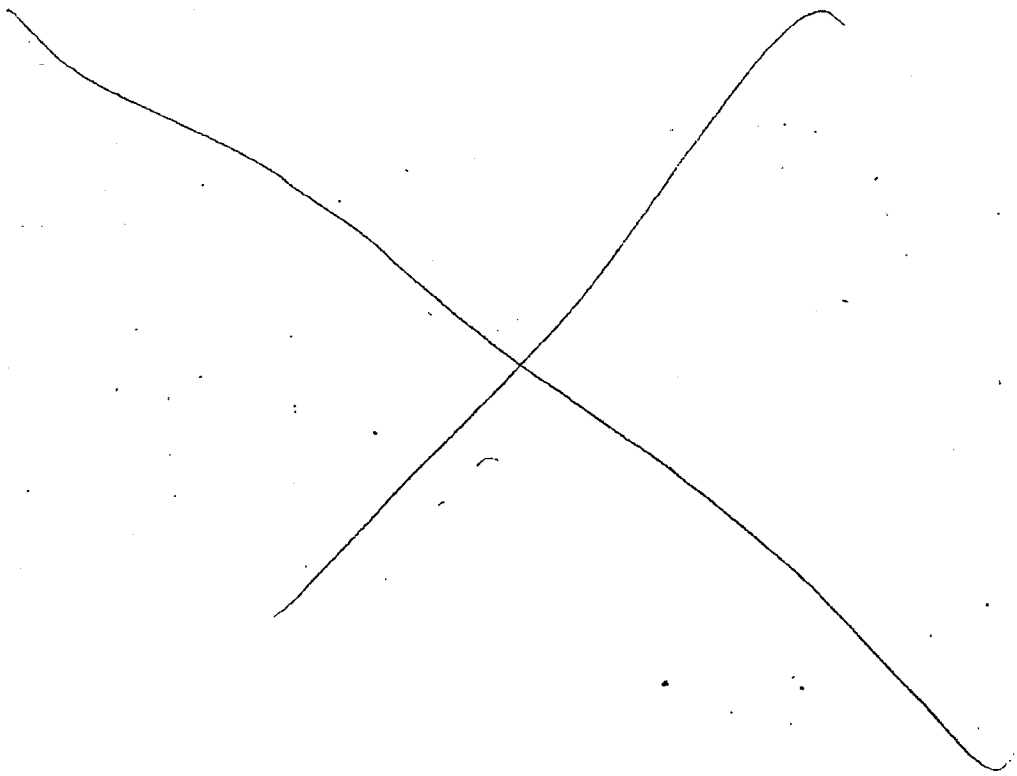
9. STATEMENT *(Continued)*



INITIALS OF PERSON MAKING STATEMENT _____ PAGE OF PAGES

EXHIBIT 31

9. STATEMENT *(Continued)*



AFFIDAVIT

I, (b)(6), (b)(7)(C) [redacted], HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT WHICH BEGINS ON PAGE 1, AND ENDS ON PAGE ____. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OF BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFLUEN(b)(6), (b)(7)(C) [redacted]

(Signature of Person Making Statement)

WITNESSES:

ORGANIZATION OR ADDRESS

ORGANIZATION OR ADDRESS

Subscribed and sworn to before me, a person authorized by law to administer oaths, this _____ day of _____, _____ at _____

(Signature of Person Administering Oath)

(Typed Name of Person Administering Oath)

(Authority To Administer Oaths)

INITIALS OF PERSON MAKING STATEM(b)(6), (b)(7)(C) [redacted]

PAGE OF PAGES

DSAPA V1.00

PAGE 3, DA FORM 2823, DEC 1998

SWORN STATEMENT

For use of this form, see AR 190-45; the proponent agency is DCSOPS

0315-05-CID789-39270

PRIVACY ACT STATEMENT

AUTHORITY: Title 10 USC Section 301; Title 5 USC Section 2951; E.O. 9397 dated November 22, 1943 (SSN).
PRINCIPAL PURPOSE: To provide commanders and law enforcement officials with means by which information may be accurately identified.
ROUTINE USES: Your social security number is used as an additional/alternate means of identification to facilitate filing and retrieval.
DISCLOSURE: Disclosure of your social security number is voluntary.

1. LOCATION	2. DATE (YYYYMMDD)	3. TIME	4. FILE NUMBER
86 CASH	20050724	1338	

5. LAST NAME, FIRST NAME, MIDDLE NAME	6. SSN	7. GRADE/STATUS
(b)(6), (b)(7)(C)	(b)(6), (b)(7)(C)	E4

8. ORGANIZATION OR ADDRESS
C 3/7 CAV

9. I, (b)(6), (b)(7)(C), WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:

At Aprox 0600 24 July sec, patrol became under small arms fire while in Baqubah. The two individuals ran into a house while exchanging contact, we attempted to breach with a grenade the two guys inside sustained injuries from the blast, we then immediatly transported them to the CASH

Nothing follows

10. EXHIBIT	11. INITIALS OF PERSON MAKING STATEMENT	PAGE 1 OF ____ PAGES

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT OF ____ TAKEN AT ____ DATED ____"

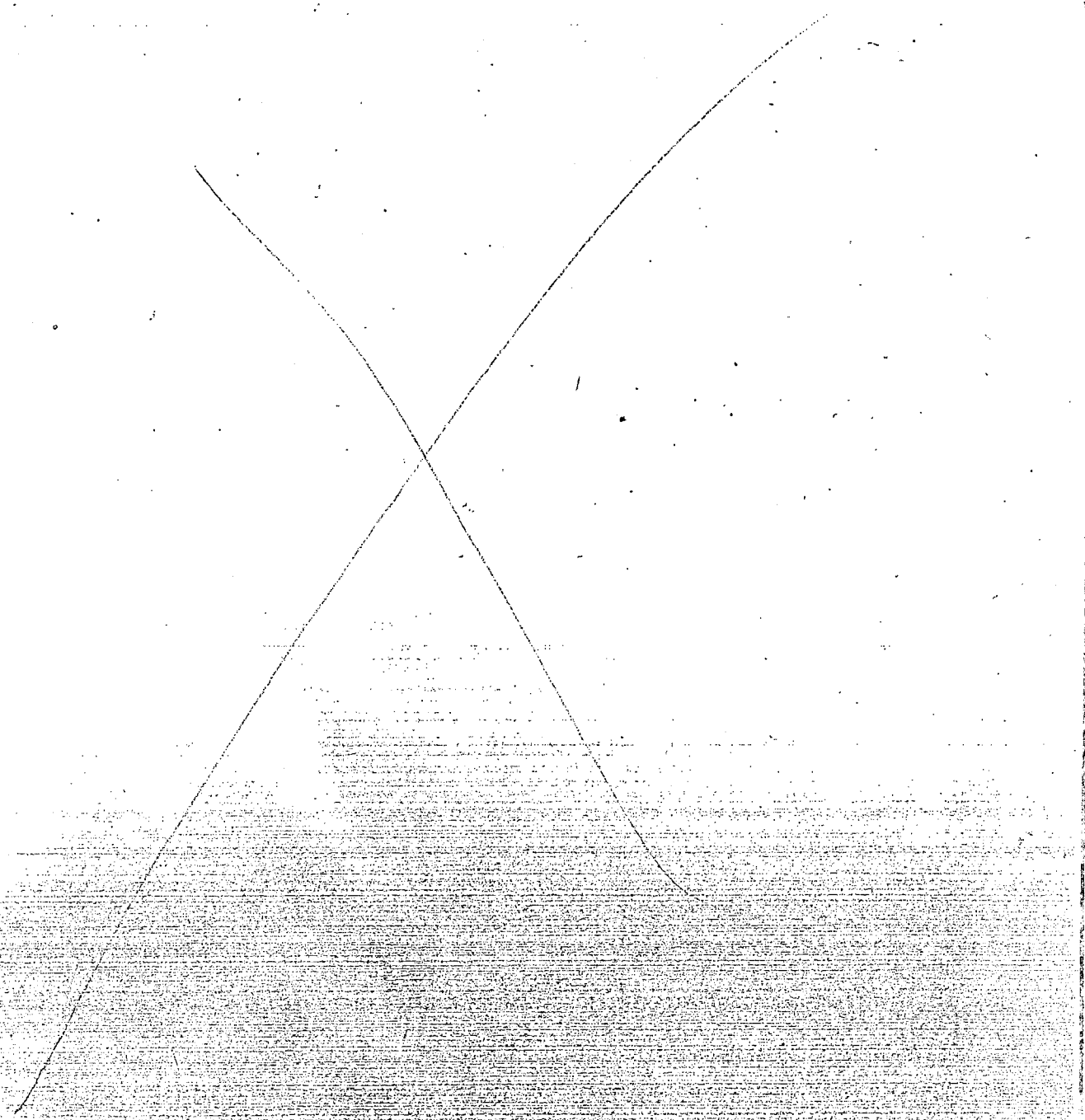
THE BOTTOM OF EACH ADDITIONAL PAGE MUST BEAR THE INITIALS OF THE PERSON MAKING THE STATEMENT, AND PAGE NUMBER MUST BE BE INDICATED.

DA FORM 2823, DEC 1998 DA FORM 2823, JUL 72, IS OBSOLETE USAPA V1.00

EXHIBIT 36

STATEMENT OF _____ TAKEN AT _____ DATED _____

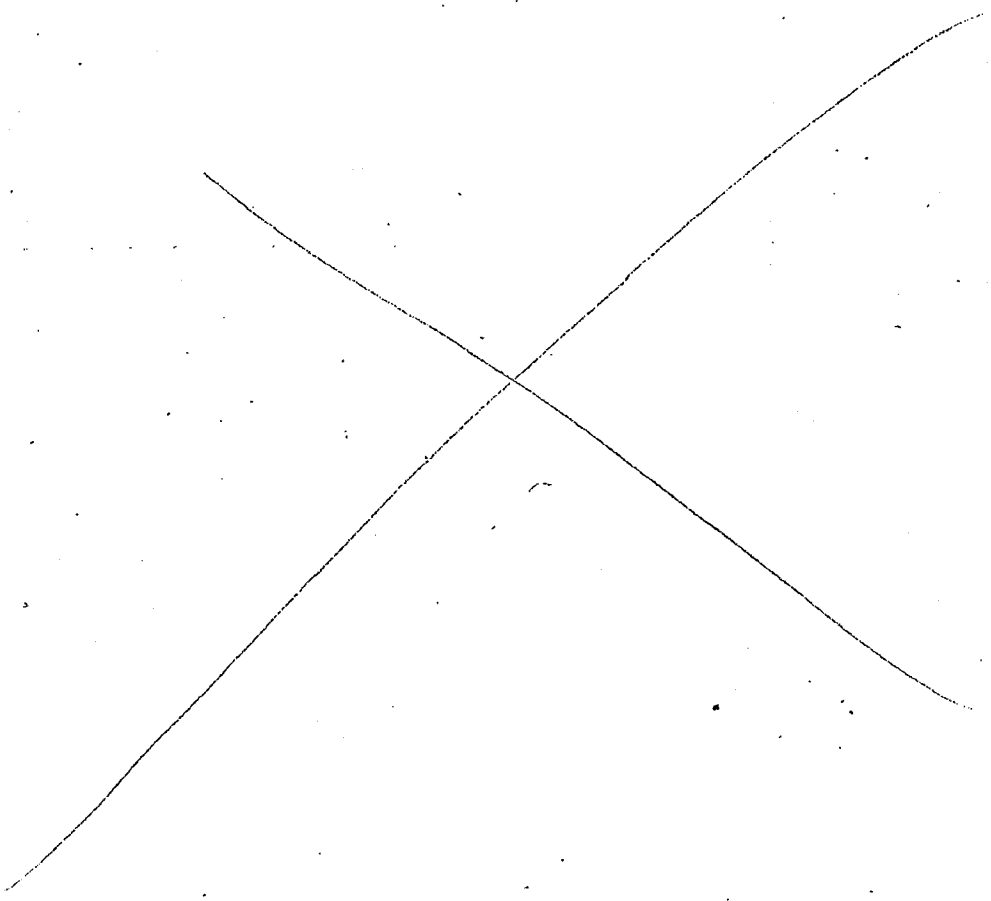
9. STATEMENT *(Continued)*



INITIALS OF PERSON MAKING STATEMENT _____ PAGE 2 OF 2 PAGES

EXHIBIT 37 3

9. STATEMENT (Continued)



AFFIDAVIT

I (b)(6), (b)(7)(C) _____, HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT WHICH BEGINS ON PAGE 1, AND ENDS ON PAGE_____. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OF BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFLUENCE OR UNLAWFUL INDUCEMENT.

(b)(6), (b)(7)(C)

(Signature of Person Making Statement)

WITNESSES:

_____

_____

_____

ORGANIZATION OR ADDRESS

_____

_____

_____

ORGANIZATION OR ADDRESS

Subscribed and sworn to before me, a person authorized by law to administer oaths, this _____ day of _____, _____ at _____

_____

(Signature of Person Administering Oath)

_____

(Typed Name of Person Administering Oath)

_____

(Authority To Administer Oaths)

INITIALS OF PERSO (b)(6), (b)(7)(C)

PAGE OF PAGES

USAPA V1.00

PAGE 3, DA FORM 2823, DEC 1998

EXHIBIT 38

EXHIBIT

39

RECEIPT FOR INMATE OR DETAINED PERSON

1. RECEIVED FROM *(Unit or Agency and Station)* SPC (b)(6), (b)(7)(C) C Co. 1-151 FA (86th CS4)	2. TIME	3. DATE *(YYYYMMDD)* 26 July 05
4. INMATE NAME *(Last, First, Middle)* pvt # 3586	5. SSN	6. GRADE
7. ORGANIZATION	8. STATION	
9. OFFENSE		
10. PERSONAL PROPERTY		
11. REMARKS		
12. NAME AND TITLE OF PERSON RECEIVING ABOVE INDIVIDUAL	13. SSN	14. GRADE
15. RECEIVING UNIT OR AGENCY AND STATION	16. SIGNATURE	

DD FORM 2708, NOV 1999

Exhibit 4

Pages 40 thru 46 referred to:

CDR USAMEDCOM
ATTN: FOIA Office, STOP 76
1216 Stanley RD 2D FL
FT. Sam Houston, TX 78234-5049

ARMED FORCES INSTITUTE OF PATHOLOGY
Office of the Armed Forces Medical Examiner
1413 Research Blvd., Bldg. 102
Rockville, MD 20850
301-319-0000

FINAL AUTOPSY EXAMINATION REPORT

Name: Unknown, Unknown
Detainee No.: Unknown
Date of Birth: Unknown
Date of Death: (b)(6) 2005
Date of Autopsy: 30 AUG 2005
Date of Report: 21 OCT 2005

Autopsy No.: (b)(6)
AFIP No.: (b)(6)
Rank: Unknown
Place of Death: Iraq
Place of Autopsy: Port Mortuary, Dover AFB, DE

Circumstances of Death: This unknown male died in the medical treatment facility at Abu Ghraib where he was being treated for injuries sustained during a violent encounter with coalition forces. According to some of the medical records received, he never regained consciousness after surgery and his postoperative course included necrotizing fasciitis.

Authorization for Autopsy: Armed Forces Medical Examiner, per 10 U.S. Code 1471

Identification: No positive means of identification is available. A false SSN 20 801 05 0726 appears on hospital paperwork. An ID band on the left wrist of the decedent contains "Unknown, Unk, 20 801 05 0726 M.O. Detainee". An ID band on the left ankle contains "Doe, John 100-00-3586".

CAUSE OF DEATH: **Complications of Blast and Ballistic Injuries**

MANNER OF DEATH: **Homicide**

EXHIBIT

FINAL AUTOPSY DIAGNOSES:

I. Blast and Ballistic Injuries

A. Penetrating Ballistic Wound of the Left Thigh and Torso
1. Entrance: Anterior left thigh (25 ¾-inches above the instep of the left foot and 3 ½-inches medial to the anterior midline of the left thigh), 1 ¼ x ½-inch ovoid wound packed with gauze
2. Wound Path: Skin, subcutaneous tissue and muscle of the left thigh, left inguinal area and lower left pelvis, possibly breaching the peritoneal cavity and injuring intraperitoneal organs
3. Recovered: Retroperitoneal hemorrhage situated 35-inches above the instep of the left foot and 2 ½-inches left of the anterior midline of the body; no shrapnel fragments recovered, but small metallic fragment in the left inguinal area visible on radiographic imaging
4. Wound Direction: Left to right, front to back, and upward
5. Associated Injuries: Extensive retroperitoneal hemorrhage; possibly associated with injuries to the ascending colon and small intestine

B. Two granulating wounds of the anterior neck
C. Multiple small penetrating wounds of the anterior torso, some possibly resulting in internal injuries but surgical intervention precludes definitive assessment
D. Abrasion of the right flank, possibly postmortem
E. Laceration of the right external ear
F. Abrasion of the left upper back
G. History of shrapnel and thermal injuries, with debridement of tissue from the torso and amputation of the right upper extremity

II. Medical Complications of Injuries
A. Multiple organ system failure by history
B. Bilateral pleural effusions (110-milliliters of serosanguinous fluid right; 150-milliliters of serosanguinous fluid left)
C. Pericardial effusion (70-milliliters)
D. Lungs with changes of adult respiratory distress syndrome
E. Changes consistent with hepatic failure

III. Mild atherosclerotic cardiovascular disease; no other evidence of significant natural disease processes, within the limitations of the examination

IV. Decomposition changes, including green-brown discoloration and marbling of soft tissue, skin slippage, and softening of solid organs

V. **Toxicology is negative for ethanol and cyanide. Morphine is present in the urine but not detected in the liver. Diphenhydramine is present in the liver at a concentration of 0.24 mg/kg. Fentanyl is present in the liver at a concentration of 0.13 mg/kg.**

EXTERNAL EXAMINATION

The remains are received unclothed and wrapped in a blue-green blanket. The body is that of a well-developed, overweight appearing, 68 ½-inches, 193-pounds, male. Lividity is posterior and fixed, except in areas exposed to pressure. Rigor has passed and the body is in a moderate state of decomposition as evidenced by vascular marbling, skin slippage, and green discoloration. The body temperature is that of the refrigeration unit.

The scalp is covered with black hair in a normal distribution. The corneae are cloudy. The sclerae are unremarkable. The irides are brown and the pupils are round and equal in diameter. Injuries of the head will be described. The teeth are natural and in fair condition. Facial hair consists of a short black beard and mustache.

The neck is mobile and the trachea is midline. Injuries of the torso will be described. The chest is symmetric. The abdomen is protuberant. The external genitalia are those of a normal adult, circumcised, male. There is marked scrotal edema. The testes are descended and free of masses. Pubic hair is present in a normal distribution.

The extremities are without clubbing or edema. The right upper extremity is absent. The fingernails on the left hand are intact. A ¼-inch scar is on the lateral aspect of the right thigh. No tattoos or other significant body marks are noted. A hospital identification band is on the left wrist with "Unknown, Unk, 20 801050726, M.O. Detainee". Another identification band is on the left ankle and contains "Doe, John 100-00-3586"

MEDICAL INTERVENTION

At the time of the autopsy the following evidence of medical intervention is noted:

- Nasogastric intubation and tracheostomy
- Foley catheter with 500-milliliters of brown urine in the collection bag
- Debridement of skin and soft tissue encompassing a 30 x 11 ½-inch area over the right chest and abdomen
- Sutured midline abdominal surgical incision (9-inches); postoperative changes of the bowel with anastomosis of the ileum to the transverse colon
- Sutured wound of the right ear
- Vascular access devices in the left femoral area and left wrist
- Gauze dressing packing and covering a left thigh wound and the right anterior torso debridement area
- Surgical amputation of the right upper extremity at the proximal right arm

RADIOGRAPHS

A complete set of postmortem radiographs is obtained and demonstrates the injuries as described.

EVIDENCE OF INJURY

I. Blast and Ballistic Injuries

A. Penetrating Ballistic Wound of the left Thigh and Torso

There is a ballistic entrance wound on the left thigh, situated 25 ¾-inches above the left instep and 3 ½-inches medial to the anterior midline of the left thigh. The wound is 1 ¼ x ½-inch and packed with gauze. The wound path goes through the skin, subcutaneous tissue and muscle of the left thigh, the left inguinal area and the lower left pelvis, possibly breaching the peritoneal cavity and injuring intraperitoneal organs (surgical intervention and remoteness of the injury precludes definitive wound path identification). There is extensive retroperitoneal hemorrhage situated 35-inches above the instep of the left foot and 2 ½-inches left of the anterior midline of the body. No shrapnel fragments recovered, but small metallic fragments in the left inguinal area visible on radiographic imaging. Postoperative changes in the small intestine and colon likely are associated with this wound path as there are no entrance wounds on the torso. The wound path is directed left to right, front to back, and upward.

B. Other Injuries

Multiple superficial wounds in varying stages of healing are on the right side of the face and range up to 1-inch in greatest dimension. The area includes the right external ear, which has sutured 3-inch laceration that has been surgically closed. Two wounds that extend into muscle are present on the neck, right of the anterior midline. One is 1 ¼ x 1-inch and the other is 1 ½ x 1 ¼-inches. These are showing evidence of healing by secondary intention. There are multiple small defects in the skin and subcutaneous tissue of the anterior torso that are in varying stages of healing. A 30 x 11 ½-inch area of skin and soft tissue is debrided from the right chest and upper abdomen, obscuring any possible injuries in these areas. A penetrating wound of the anterior torso resulting in the abdominal injuries described above cannot be excluded. A ¾ x ½-inch abrasion is on the right flank that is likely postmortem. There is a 4 ¾ x ¼-inch linear abrasion on the left upper back that is within an area of skin slippage. The right upper extremity is surgically absent at the proximal right humerus, precluding evaluation of injuries to that extremity.

INTERNAL EXAMINATION

HEAD:

The scalp is atraumatic. There are no injuries to the head, except for the previously described injuries to the right side of the face. Reflection of the scalp reveals no other injuries. The calvarium is intact and there are no skull fractures. The inner surface of the calvarium is light yellow in color. The brain is free of injury and sectioning reveals no evidence of natural disease processes. The brain weighs 1400-grams.

NECK:
The strap muscles of the anterior neck are homogenous and red-brown, without hemorrhage. The thyroid cartilage and hyoid bone are intact. The larynx is lined by intact white mucosa, with perforation of the anterior aspect for a tracheostomy. The thyroid gland is symmetric and red-brown, without cystic or nodular change. The tongue is free of injury. The atlanto-occipital joint is intact.

BODY CAVITIES:
The right pleural cavity contains 110-milliters of serosanguinous fluid and the left pleural cavity contains 150-milliliters of serosanguinous fluid. The peritoneal cavity contains 20-milliliters of serosanguinous fluid. The pericardial sac contains 70-milliliters of serosanguinous fluid. There is extensive retroperitoneal hemorrhage on the right. The organs occupy their usual anatomic positions.

RESPIRATORY SYSTEM:
The right and left lungs weigh 1050 and 1080-grams, respectively, and are markedly congested. The pulmonary parenchyma is diffusely congested and firm. No mass lesions or areas of consolidation are present. The pulmonary arteries are unremarkable.

CARDIOVASCULAR SYSTEM:
The heart weighs 350-grams. The epicardial surface has minimal fat investment. The coronary arteries have a normal appearance and branch in a right-dominant distribution. There is mild coronary atherosclerosis, as evidenced by 25% luminal narrowing of the left anterior descending and right coronary arteries and 20% luminal narrowing of the left circumflex coronary artery. The thicknesses of the left ventricle, septum, and right ventricle are 1.1, 1.1, and 0.5 centimeters, respectively. The cardiac chambers and valves are grossly normal. The myocardium is moderately softened. The aorta gives rise to three intact and patent arch vessels. Injuries to the aorta have been described previously. The renal and mesenteric vessels are unremarkable.

LIVER & BILIARY SYSTEM:
The 1960-gram liver is uninjured. The parenchyma is yellow-brown and congested with the usual lobular architecture. No mass lesions or other non-traumatic abnormalities are noted. The gallbladder contains 40-milliliters of green-black bile and no stones. The mucosal surface is green and velvety. The extrahepatic biliary tree is patent.

SPLEEN:
The 470-gram spleen has a smooth, intact, red-purple capsule. The parenchyma is soft, maroon, congested, and unremarkable.

PANCREAS:
The pancreas is uninjured and grossly normal, except for decomposition changes. The usual lobular architecture is present. No mass lesions or other abnormalities are seen.

EXHIBIT 4

ADRENAL GLANDS:
The right and left adrenal glands are symmetric, with yellow cortices, gray medullae, and decomposition changes. No masses or areas of hemorrhage are identified.

GENITOURINARY SYSTEM:
The right and left kidneys weigh 200 and 210-grams, respectively. The external surfaces are intact and smooth. The cut surfaces are red-tan and slightly congested, with uniformly thick cortices and distinct corticomedullary junctions. The pelves are unremarkable and the ureters are normal in course and caliber. White bladder mucosa overlies an intact bladder wall. The urinary bladder is empty. The prostate gland is normal in size, with lobular, yellow-tan parenchyma. The seminal vesicles are unremarkable. The testes are uninjured.

GASTROINTESTINAL TRACT:
The esophagus is intact and lined by smooth, gray-white mucosa. The gastric wall is intact. The stomach contains 150-milliliters of viscous, dark brown fluid. The small bowel and colon are remarkable for surgical absence of the ascending colon. The appendix is absent.

MUSCULOSKELETAL:
No non-traumatic abnormalities of muscle or bone are identified.

MICROSCOPIC EXAMINATION

Select portions of major organs are retained in formalin, without preparation of microscopic slides.

Autopsy (b)(6)
Unknown, Ukn Detainee

ADDITIONAL PROCEDURES/REMARKS

- Documentary photographs are taken by OAFME staff photographers
- Specimens retained for toxicologic testing and/or DNA identification are: heart blood, spleen, liver, lung, brain, bile, kidney, urine, gastric contents, adipose tissue, and psoas muscle
- The dissected organs are forwarded with the body
- (b)(6) USACID attended the autopsy

OPINION

This unknown Iraqi detainee died as a result of complications of blast and shrapnel injuries. The decedent had received surgical and medical treatment in a U.S. medical treatment facility. The autopsy disclosed evidence of his initial injuries, although a definitive description of his exact injuries is precluded by surgical intervention and healing. The medical complications of his injuries included multiple organ-system failure. Therapeutic medications were noted on toxicologic testing. The manner of death is homicide.

(b)(6)

(b)(6) Medical Examiner

Exhibit 7

Page 51 referred to:

CDR USAMEDCOM
ATTN: FOIA Office, STOP 76
1216 Stanley RD 2D FL
FT. Sam Houston, TX 78234-5049

(0150-05-CID112)

0115-05-CID789-39270

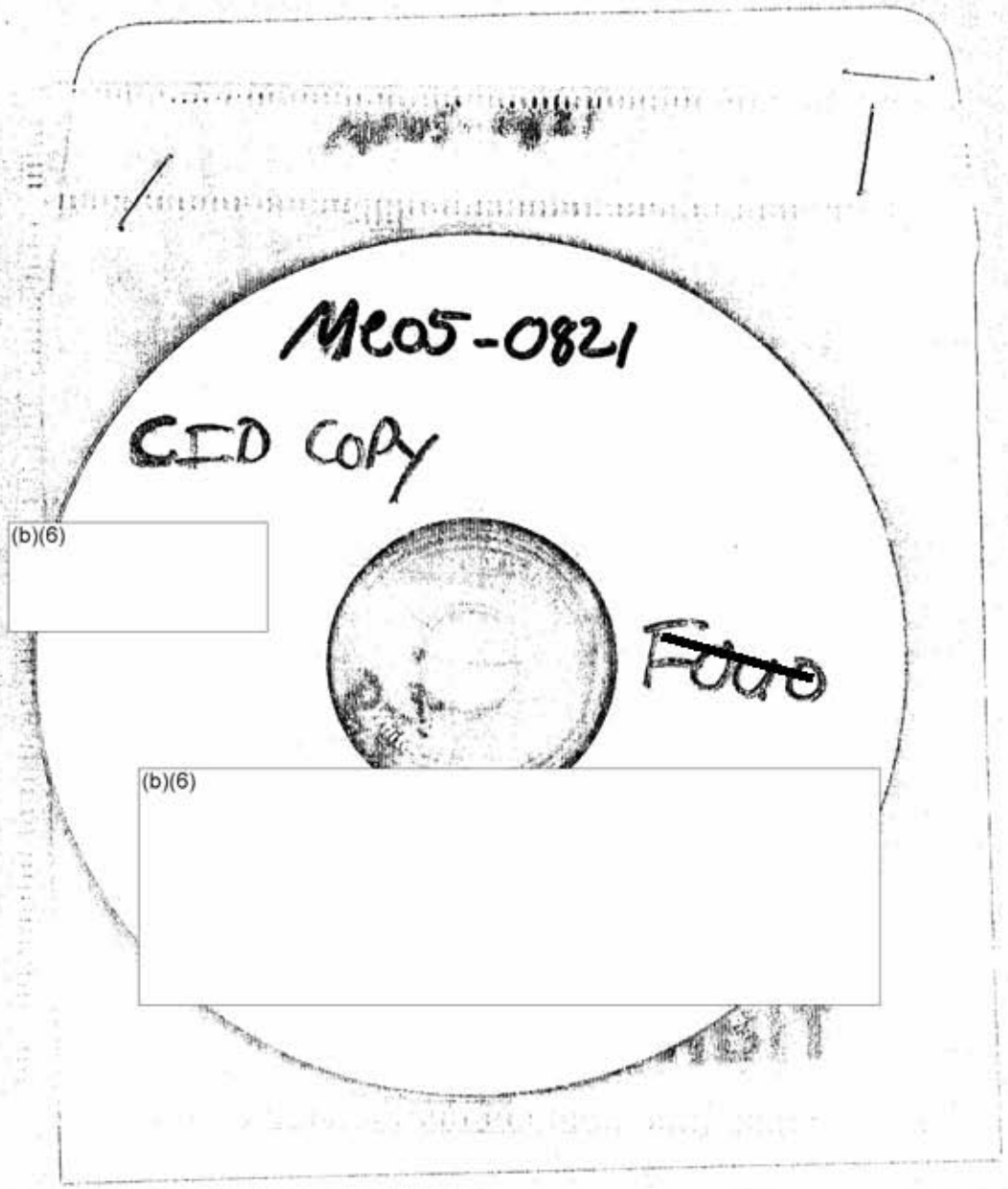


EXHIBIT 7/51

AGENT'S INVESTIGATION REPORT	ROI NUMBER (0150-05-CID112) 0115-05-CID789-39270
CID Regulation 195-1	PAGE 1 OF 2 PAGES

DETAILS

About 0700, 30 Aug 05, this office was notified by SA (b)(2), (b)(6), (b)(7)(C) Investigative Operations/CID Liaison, Office of the Armed Forces Medical Examiner, Armed Forces Institute of Pathology (AFIP), 1413 Research Blvd, Building 102, Rockville, MD 20850, that the remains of an unidentified detainee, had arrived at Dover Air Force Base (DAFB), DE 19902, and autopsy to be conducted later that morning. The detainee was reportedly involved in an altercation with U.S. Coalition Forces, was captured, incarcerated, and hospitalized at the Baghdad Central Confinement Facility (BCCF), Abu Ghraib, Iraq.

Agent's Comment: The remains arrived with a different set of medical records, which clearly conflicted with the injuries present of detainee.

About 1330, 30 Aug 05, SA (b)(6), (b)(7)(C) attended the autopsy of the unidentified detainee (ME #05-821), which was conducted by Dr. (CDR) (b)(6), (b)(7)(C) (b)(6), (b)(7)(C) USN, Chief Deputy Medical Examiner, Deputy Medical Examiner, Office of the Armed Forces Medical Examiner (OAFME), Rockville, MD 20850. Dr. (b)(6), (b)(7)(C) indicated further information needed to be provided prior to opining on this autopsy. No evidence was collected. Photographers from OAFME exposed digital photographs of the autopsy and prepared the compact disk containing all images exposed. A copy of the compact disk (CD) containing those images was obtained. SA (b)(6), (b)(7)(C) noted that significant injuries were: amputation of right arm below just below shoulder, major trauma to right abdomen/torso area. Further, a medical wrist band was identified on the left wrist detailing the following: (b)(6), (b)(7)(C) UNKNOWN, UNK…DETAINEE" and on left ankle a wrist band detailing the following, manufacturer's markings, "BOY, [unintelligible manufacturer markings below BOY]," and handwritten markings, (b)(6), (b)(7)(C) (See Photo CD)

Agent's Comment: Dr. (b)(6), (b)(7)(C) indicated that OAFME would coordinate within Casualty Affairs channels to determine the properly identity of this unidentified person.

About 1400, 30 Aug 05, SA (b)(6), (b)(7)(C) coordinated this investigation with SA (b)(6), (b)(7)(C) 48th Military Police Detachment (CID)(FWD)(-), who provided supporting details concerning this investigation for autopsy purposes. Further, it was determined that 100-00-3686 was issued to the

TYPED AGENT'S NAME AND SEQUENCE NUMBER	ORGANIZATION	
SA (b)(2), (b)(6), (b)(7)(C)	Aberdeen Proving Ground Resident Agency Aberdeen Proving Ground, MD 21005	
S (b)(6), (b)(7)(C)	DATE 18 Sep 05	EXHIBIT 6

AGENT'S INVESTIGATION REPORT	ROI NUMBER (0150-05-CID112) 0115-05-CID789-39270
CID Regulation 195-1	PAGE 2 OF 2 PAGES

DETAILS

unknown detainee for Hospital tracking at 86th CSH, International Zone, Baghdad, Iraq, according to a Discharge Summary. Additionally, the number (b)(6), (b)(7)(C) was found as the patient identification on Hospital Death Report (DA Fm 3894) pertaining to the unknown detainee. This information was relayed to Dr. (b)(6), (b)(7)(C)

About 1500, 18 Sep 05, SA (b)(6), (b)(7)(C) coordinated with Dr. (b)(6), (b)(7)(C) who provided a preliminary opine concerning the autopsy results of the unidentified detainee. Dr. (b)(6), (b)(7)(C) stated that preliminary opine concerning Cause of Death was blast injuries with complications, and the Manner of Death was Homicide. Dr. (b)(6), (b)(7)(C) indicated that sufficient information existed to believe that case OAFME# 05-821 was the Unknown Detainee who died on Aug 05, due to an altercation with U.S. Coalition Forces. Dr. (b)(6), (b)(7)(C) provided this office with a copy of the preliminary autopsy report..

AGENT'S COMMENT: The official results of the autopsy will be documented in the Final Autopsy Report, which will be posted when completed, to the Army Knowledge Online (AKO), by SA (b)(2), (b)(6), (b)(7)(C) Operational Investigations, OAFME, AFIP, 1413 Research Blvd, Building 102, Rockville, MD 20850.///Last Entry///

TYPED AGENT'S NAME AND SEQUENCE NUMBER	ORGANIZATION	
SA (b)(2), (b)(6), (b)(7)(C)	Aberdeen Proving Ground Resident Agency Aberdeen Proving Ground, MD 21005	
SIGNATURE (b)(6), (b)(7)(C)	DATE 18 Sep 05	EXHIBIT 6